DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/26/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G224	A. BUILDING _____ B. WING _____	05/08/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO	505 1/2 57TH STREET NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from May 6, 2009 through May 8, 2009. The survey was initiated using the fundamental survey process. A random sample of four clients was selected from a resident population of seven men with various disabilities. The findings of the survey were based on observations, interviews with clients, one guardian, interviews with staff in the home and at one day program, as well as a review of client and administrative records, including incident reports.	W 000	6/8/09 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that staff consistently implemented policies developed to protect client health and safety, for five of the seven residents of the facility. (Clients #2, #4, #5, #6 and #7) 1. Cross-refer to W153. Staff failed to prepare incident reports for injuries of unknown origin sustained by Clients #2 and #6, in accordance with the incident management policy. 2. Cross-refer to W154.2. Based on interview and record review, the facility failed to thoroughly investigate an April 6, 2009 incident involving Client #6. The investigation failed to mention the driver who, by one eye witness account, was driving recklessly at the time of the incident.	W 149	1. See response to W153.	6/30/09
			2. See response to W154.	6/30/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Marsha H. Thompson	Director of Disability Services	6/5/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 149	Continued From page 1 3. Based on observation and interview and record review, facility staff failed to implement the policy on transportation safety, as follows: a. On May 7, 2009, at 8:32 AM, observations revealed that facility staff failed to ensure that Clients #5, #6 and #7 were properly secured by seat belt prior to being transported in the facility's van, in accordance with District of Columbia law and facility policies. Once the observation was brought to the House managers attention by the surveyor, he instructed the staff to assist in securing their seatbelts. It should be noted that another vehicle reportedly was undergoing repairs of its seat belts at the time of the survey. b. According to an incident report dated April 6, 2009 and its corresponding investigation report dated April 13, 2009, Client #6 sustained an injury to his forehead when his wheelchair "flipped" while riding in the facility van. According to the investigation report, a direct support staff and the Residence Director (RD) received disciplinary action after findings of neglect. Staff reportedly had not properly secured the client's wheelchair before driving, and the RD reportedly had not ensured that staff were effectively trained on properly securing wheelchairs when riding in vehicles. Note: It should be noted that an outside monitoring entity recognized the facility's failure to identify and classify this incident as neglect in accordance to their incident policy and procedures. After further instruction was given to the agency to reclassify and resubmit, it was at that time the agency investigated and determined neglect.	W 149	3. The Governing Body will ensure that the new Residence Director follows policy regarding transportation safety by ensuring she is trained on the policy and that the QMRP does spot checks on how clients are securely seated prior to being driven in the van. 6/30/09	

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W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and review of incident reports and resident records, the facility failed to ensure that all injuries of unknown origin were reported immediately to the administrator and/or the Department of Health (DOH), Health Regulation Administration, for two of the seven clients residing in the facility. (Clients #2 and #6) The findings include: 1. On May 6, 2009, at approximately 4:24 PM, interview with the Qualified Mental Retardation Professional (QMRP) and Residence Director (aka House Manager) revealed that there had been one injury of unknown origin discovered within the past four months. They described how on April 30, 2009, staff discovered a scratch 1 1/2 inches in length on Client #6's right shoulder while doing personal care. The QMRP stated that she "got a note from staff... I'm still reviewing the incident." Review of the corresponding incident report revealed no evidence that the agency's administrator and/or DOH/HRA received immediate notification. A pre-survey review of incidents reported to the State agency failed to show evidence that this incident had been reported. During the May 6, 2009 interview, the QMRP stated that according to their policies,	W 153	1. The Quality Management Director will re-train all staff on incident reporting and management. All staff will be assigned to attend incident management training at DDS. All newly hired staff are, and will continue to be, trained on incident reporting and management during their orientation. 6/30/09	

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W 153	Continued From page 3 every injury of unknown origin must be reported immediately to their administrator and to DOH. 2. On May 7, 2009, further review of incident reports revealed that on January 21, 2009, staff discovered a scratch on Client #2's forehead. According to the incident report, a nurse cleaned the scratch, applied Neosporin ointment and then notified the QMRP. The incident report did not document notification of DOH and a pre-survey review of incidents reported to the State agency failed to show evidence that this incident had been reported.	W 153	2. See response to #1 above.	6/30/09
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to thoroughly investigate all injuries of unknown origin and/or incidents of neglect, for four of the seven clients residing in the facility. (Clients #2, #3, #4 and #6) The findings include: 1. On May 6, 2009, at approximately 4:26 PM, the Qualified Mental Retardation Professional stated that facility policies required that all injuries of unknown origin must be investigated. On May 7, 2009, beginning at 3:38 PM, review of incident reports in the facility revealed the following injuries of unknown origin: a. Cross-refer to W153.1. On April 30, 2009, staff discovered a scratch 1 1/2 inches in length	W 154	1. See response to W153. The Quality Management Director will re-open the investigations to attempt to determine the source of the injuries.	6/30/09

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W 154	Continued From page 4 on Client #6's right shoulder while doing personal care. As of May 8, 2009, the potential source of the injury had not been investigated. b. Cross-refer to W153.2. On January 21, 2009, staff discovered a scratch on Client #2's forehead. There was no evidence that the source of this injury had been investigated. 2. On May 7, 2009, beginning at 3:38 PM, review of incident reports and corresponding investigations revealed that on April 6, 2009, Client #4 sustained an injury to his forehead while riding in a facility van. The client's 1:1 direct support staff who was riding in the vehicle at the time of the incident, was interviewed in the facility a short while later, beginning at approximately 4:20 PM. He said the driver had secured the client's wheelchair that day, since he was new and had not yet received training. The 1:1 staff also stated that he had been placed on leave and the driver was terminated for "restless driving". (It was unclear if the driver's termination was related directly to this incident.) Immediate review of the corresponding investigation report, dated April 13, 2009, revealed that the 1:1 staff and the Residence Director/House Manager (RD/HM) were interviewed. Further review of the investigation showed no evidence that the driver of the vehicle had been interviewed (she was not mentioned in the report). The investigation report also contradicted other elements of the 1:1 staff's account of the incident. For example, the report stated that the 1:1 had secured the wheelchair straps (improperly) that day. Beginning at 4:52 PM, Client #4's 1:1 was again	W 154	2. The staff who were responsible for the incident have been disciplined and/or retrained in properly securing seating for clients in the van. New staff will be properly trained in tie-downs for wheelchairs prior to operating the van or accompanying clients on the van.	6/30/09

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W 154	Continued From page 5 interviewed for clarification. He repeated that the driver had secured the wheelchair that afternoon. He denied having been interviewed by the Incident Management Coordinator (IMC), stating that the only administrative staff he spoke with was their Director ("with red hair") who informed him that he would be placed on administrative leave, as a routine policy. On May 8, 2009 at approximately 10:15 AM (and again at 10:35 AM), the RD/HM agreed to seek copies of the written interviews of both the driver and the 1:1 staff (interview form, Attachment D to the Facility's 2007 Incident Management policy); however, no additional information was shared before the survey ended later that evening. The facility's investigative report determined that the 1:1 staff had been neglectful in not securing the client's wheelchair properly in the vehicle. The investigation also found the RD/HM had been neglectful for not ensuring that staff were trained on properly securing clients' wheelchairs. It should be further noted that the Physical Therapist documented having provided staff training on properly securing wheelchairs in vans, in response to the April 6, 2009 incident.	W 154		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observations, interview and record review, the facility failed to ensure that each client's active treatment program was integrated,	W 159		

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W 159	Continued From page 6 coordinated and monitored by the Qualified Mental Retardation Professional (QMRP), for two of four clients in the sample. (Clients #3 and #4) The findings include: 1. The QMRP failed to ensure that the day program was made aware of Client #3's prescribed plate guard to assist with feeding as evidenced below: On May 6, 2009, at approximately 5:50 PM, Client #3 was observed to use a plate guard to assist with feeding during his dinner meal. There was no spilling observed. Observations conducted at the day program on May 7, 2009, at 11:33 AM revealed Client #3 ate from a foam divided plate during lunch. At 11:37 AM, Client #3 was observed to use his left hand to prevent food from falling off his spoon as he brought the food toward his mouth. At 11:41 AM, food was observed to fall off Client #3's plate as he tried to scoop the food up with his spoon. Interview with the Day Program (DP) staff at 11:43 AM confirmed that Client #3 was using his left hand to support food from falling off his spoon. Further interview with DP staff revealed that Client #3 was not prescribed any adaptive equipment for feeding. Interview with the DP Case Manager by telephone on the same day, at approximately 2:30 PM, revealed that he was not aware that Client #3 was prescribed a plate guard. Interview with the Qualified Mental Retardation Professional (QMRP) on May 7, 2000, at approximately 3:30 PM, revealed that she was unaware that Client #3 was without a plate guard	W 159	1. The QMRP will make at least a monthly visit to each client's day program, and will assign the Residence Director to also make at least a monthly visit. The visit and findings, as well as corrective actions needed, will be documented in each client's record.	6/30/09

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W 159	Continued From page 7 at the day program. Further interview with the QMRP revealed that she had not observed a lunch meal at the day program. Review of Client #3's records on May 8, 2009, at 12:06 PM revealed a medical consult dated July 6, 2008. According to the consult, Client #3 had an Occupation Therapy Evaluation dated July 6, 2008 that required an "adaptive plate guard to prevent spillage." 2. Cross-refer to W252. The QMRP failed to ensure staff documented behavior data in accordance with the behavior support plans of Clients #3 and #4. 3. Cross-refer to W192. The QMRP failed to ensure that staff were competently trained on Client #2's diet texture and nutritional supplement needs.	W 159	2. The QMRP will ensure that at least a weekly review of data is completed, and that the review is documented. When data is missing or questionable, the QMRP will ensure that staff are re-trained in data collection. 6/30/09 3. The QMRP will ensure that staff are trained in the client's dietary needs. 6/30/09	
W 192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure staff was effectively trained to implement the nutritional plan for one of four clients in the sample. (Client #2) The finding includes: The dinner meal was observed in the facility on May 7, 2009, beginning at 5:25 PM. Client #2 was served turkey cutlet (chopped fine), macaroni	W 192		

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W 192	Continued From page 8 and cheese, Brussels sprouts cut in half, 1 slice of bread cut diagonally, fruit cocktail, apple juice and a tall beverage glass of what staff referred to as "Ensure." The need for additional staff training was evidenced by the following: 1. During the meal, at 5:37 PM, a can of Nepro renal supplement was brought from the pantry and presented to the Residence Director (RD) and staff assisting at the dining room table. The RD shook his head, stating that was no longer the client's supplement. He stated that Client #2 previously had received Nepro supplement; however, it had been changed recently. The RD went in the pantry and pointed to a supply of Ross Nutrition TwoCal HN with FOS supplement. He further stated that Client #2 received 2 cans of the TwoCal HN at each of his three meals per day (totaling 6 cans). Client #2's medical records had been reviewed earlier that day. At approximately 3:00 PM, review of his physician's orders (POs) revealed a telephone order dated April 1, 2009 for 1 can Nepro twice daily. An April 10, 2009 order increased the supplement to 1 can three times daily. A third telephone order (with prescription) dated April 28, 2009 was to "increase Nepro food supplement to 2 cans three times daily for albumen level..." Also on April 28, 2009, a nurse documented having telephoned the primary care physician, who confirmed the latest order. The April 28, 2009 order was Client #2's current diet order. On May 8, 2009, at approximately 2:50 PM, the Qualified Mental Retardation Professional (QMRP) was asked about Novasource Renal Supplement in the pantry. The Novasource	W 192	1. The QMRP will ensure that the Residence Director and all staff are trained in all of the clients' dietary needs.	6/30/09

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W 192	Continued From page 9 supplement was stored next to the Nepro and TwoCal HN supplements. She stated that Client #2 currently received the Novasource supplement, Client #3 received Ensure and Client #1 was tube-fed the TwoCal HN. The consulting Nutritionist was interviewed in the facility that same day, beginning at 2:55 PM. She stated that Client #2 was still prescribed Nepro supplement. She was previously unaware of the April 28, 2009 increase to 6 cans daily, as per recommendation by the nephrologist; however, she concurred with the recommendation. She further confirmed that the Ross Nutrition TwoCal HN with FOS supplement was given to Client #1 via G-tube, for nutritional sustenance. The LPN Coordinator was interviewed just moments later, in the presence of the QMRP and Nutritionist. She stated that she had trained staff on the clients' nutritional supplements. After further discussion, she acknowledged that additional training was indicated, for staff and facility managers. Beginning at 4:00 PM, review of staff in-service training records revealed the most recent nutrition training had been documented on April 23, 2009. Observations and interviews, however, revealed that the training had not been effective. 2. During the May 8, 2009 interview with the Nutritionist, at 3:25 PM, she stated that while Client #2's bread could be moistened (which was not the case at dinner on May 7, 2009), he should not have been given fruit cocktail. She further stated that she had trained staff to use a food processor to ensure ground texture. At 3:32 PM, the Residence Director was asked about their food processor. He replied "nobody is on a	W 192	2. See response to #1 above.	6/30/09

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W 192	Continued From page 10 pureed diet." He retrieved the food processor from the pantry and added that he had not seen it used since he became RD, in November 2008.	W 192		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to document behavior data in accordance with the behavior support plans (BSPs), for two of the four clients in the sample. (Clients #3 and #4) The findings include: 1. On May 6, 2009, at approximately 4:05 PM, Client #3 was observed to cry when the Qualified Mental Retardation Professional (QMRP) entered the facility and began speaking to all clients. On May 7, 2009, at approximately 6:00 PM, Client #3 was observed again crying as surveyors departed from the facility. Interview with the QMRP at approximately 4:10 PM revealed that Client #3's exhibited this behavior to gain attention. Interview with the Residence Director/House Manager at approximately 4:15 PM, revealed that unexplained crying was a part of the Client #3's BSP. On May 8, 2009, at 2:44 PM, review of Client #3's BSP dated November 29, 2008 confirmed that one of his targeted behaviors was unexplained crying. The BSP further revealed staff was to	W 252	1. The QMRP will re-train the staff on data collection; the QMRP will monitor the data collection at least weekly, and provide re-training and discipline to staff if indicated.	5/30/09

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W 252	Continued From page 11 record target behaviors on the data collection sheets on every shift, every day. Review of the behavior data collection sheets, however, revealed that staff had not documented Client #3's crying behavior on May 6 and 7, 2009. In a follow-up interview with the QMRP on May 8, 2009, at approximately 3:00 PM, she acknowledged that staff had not documented the crying as required. There was no evidence that the data had been collected in accordance with the BSP. 2. On May 6, 2009, at approximately 5:20 PM, Client #4 was verbally redirected by his 1:1 staff to stop spitting. This was observed during the medication administration. Interview with the 1:1 staff, at approximately 5:23 PM, revealed that the client had a BSP to address the targeted behavior of spitting. On May 8, 2009, at 9:19 AM, review of Client #4's BSP dated November 16, 2008 confirmed that he had a targeted behavior of spitting. The BSP further revealed staff was to record target behaviors on the data collection sheets on every shift, every day. Review of the data collection sheets, however, revealed that staff had not documented Client #4's observed spitting episode on May 6, 2009. In a follow-up interview with the QMRP and Residence Director/House Manager on May 8, 2009, at approximately 4:30 PM, they acknowledged that Client #4's 1:1 staff did not document the spitting behavior as required. There was no evidence that the data had been collected in accordance with the BSP for Client #4.	W 252	2. See response to #1 above.	6/30/09

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I 000	INITIAL COMMENTS A licensure survey was conducted from May 6, 2009 through May 8, 2009. The Group Home for Persons with Mental Retardation (GHMRP) had a resident population of seven men with various disabilities. The findings of the survey were based on observations, interviews with residents and one guardian, interviews with staff in the home and at one day program, as well as a review of resident and administrative records, including incident reports.	I 000		
I 022	3501.5 ENVIRONMENTAL REQ / USE OF SPACE Each window shall be supplied with curtains, shades or blinds, which are kept clean, and in good repair. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure windows were equipped with curtains, shades or blinds that were clean and in good repair. The finding includes: On May 8, 2009, at approximately 5:05 PM, an environmental walk-through of the interior of the GHRMP revealed the front door window was covered with a piece of cardboard box. Further observations revealed a piece of white paper covered the window on the back door. Interview with the Residence Director acknowledged that the windows to both doors should have been covered with curtains, blinds, or shades.	I 022	I. The Director of Operations will direct maintenance to supply and mount a curtain, blind, or shade to cover the windows in the doors.	6/30/09

Health Regulation Administration

Marsha H. Thompson
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Director of Disability Services
TITLE

6/30/09
(X6) DATE

STATE FORM SROV11 If continuation sheet 1 of 10

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I 082	Continued From page 1	I 082		
I 082	3503.10 BEDROOMS AND BATHROOMS Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting. This Statute is not met as evidenced by: Based on observation and interview, the facility failed to ensure all bathrooms were equipped with cup dispensers. The finding includes: During the environmental inspection and interview with the Residence Director on May 8, 2009, beginning at 5:00, revealed the hallway bathrooms utilized by the residents failed to have cups and cup dispensers.	I 082	The QMRP will ensure that the bathrooms have cups and cup dispensers.	6/30/09
I 091	3504.2 HOUSEKEEPING Housekeeping and maintenance equipment shall be well constructed, properly maintained and appropriate to the function for which it is to be used. This Statute is not met as evidenced by: Based on observations and interview, the GHRMP failed to maintain the interior and exterior of the GHMRP in a safe, clean, orderly; attractive, and sanitary manner. The findings include: Observation and interview with the Residence Director during the environmental walk through	I 091		

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I 091	Continued From page 2 on May 8, 2009, beginning at 5:00 PM, revealed the following. 1. The sink stopper located in bathroom #1 was observed to be broken. 2. Bathroom #2 was observed to have a foot and half wide hole in the wall, where the door stopper on the back of the door met the wall. 3. The carpet in the living room area located near the sofa nearest the front door was observed to have a two and half foot tear. The tear presented a potential trip hazard. 4. There was a hole, approximately four inches wide, in the overhang outside of the facility's front entrance door. 5. The cement sidewalk outside of the side entrance was severely damaged, with 3 sections of broken cement measuring 3 feet by 3 feet each. The uneven surface presented a potential trip hazard.	I 091	1. Maintenance will replace the sink stopper. 2. Maintenance will repair the hole in the wall in the bathroom at the door stopper, and will install a cushion for the stopper to prevent future damage to the wall. 3. Maintenance will replace the damaged carpet. 4. Maintenance will repair the hole above the exterior front door. 5. Maintenance will arrange for the sidewalk to be repaired.	6/30/09 6/30/09 6/30/09 6/30/09 6/30/09
I 092	3504.3 HOUSEKEEPING Each GHMRP shall be free of insects, rodents and vermin. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure it was maintained free of insects. The finding includes: During the May 6, 2009 Entrance Conference, at approximately 4:30 PM, the Qualified Mental Retardation Professional (QMRP) and	I 092	Maintenance will exterminate the facility (for ants and other insects).	6/30/09

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I 092	Continued From page 3 Residence Director (RD) both stated that there had been no reports of any insects, rodents or vermin inside the facility. A short time later, however, live ants were observed crawling on the dining room table and floor, as well as in the kitchen, living room, and in the office shared by the QMRP and RD. Live ants were again observed throughout the facility on the last two days of survey. Interview with the RD on May 8, 2009, at approximately 4:00 PM, revealed that an exterminator was last in the facility November 2008. Although the RD stated that the facility had a contract with a pest control company, he was unable to locate any receipts and/or a service contract upon request.	I 092		
I 203	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to have current job descriptions for all employees. The finding includes: On May 6, 2009, at approximately 4:45 PM, the Qualified Mental Retardation Professional agreed to make available for review the personnel records for all employees and consultants, including job descriptions. However, review of the personnel files conducted on May 8, 2009, beginning at 12:58 PM, revealed that GHMRP failed to provide evidence of job descriptions for two direct support staff (S8 and S10) that were assigned to provide 1:1 supports for Resident #4.	I 203	The Human Resources Director will provide job descriptions for all staff.	6/30/09

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I 206	Continued From page 4	I 206		
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that all staff obtained annual health certificates/ inventories. The findings include: On May 6, 2009, at approximately 4:45 PM, the Qualified Mental Retardation Professional agreed to make available for review the personnel records for all employees and consultants, including evidence of annual health certificates/ inventories. Review of the personnel records on May 8, 2009, beginning at 12:58 PM, revealed the following: 1. There were no health certificates/ inventories made available for review for 2 of the 17 direct support staff (S7 and S15) and one nurse (N3). 2. The health certificates/ inventories on file for 2 of the remaining 15 direct support staff had expired, as follows: (S2 expired on 3/3/09, and S3 7/20/06). 3. The health certificates/ inventories on file for 3 of the 7 facility nurses had expired, as follows: (N1 expired on 2/14/09; N2 on 10/22/08;	I 206	1. The Human Resources Director will ensure that all staff, nurses and consultants have current health inventories/certificates on file. 2. See response to #1 above. 3. See response to #1 above.	6/30/09 6/30/09 6/30/09

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I 206	Continued From page 5 and N4 on 3/18/09). 4. The health certificate/ inventory on file for the consulting social worker had expired on April 15, 2009. 5. The health certificate/ inventory on file for the consulting Nutritionist had expired on September 12, 2008.	I 206	4. See response to #1 above. 5. See response to #1 above.	6/30/09 6/30/09
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure staff was effectively trained to implement the nutritional plan for one of four residents in the sample. (Resident #2) The finding includes: The dinner meal was observed in the facility on May 7, 2009, beginning at 5:25 PM. Resident #2 was served turkey cutlet (chopped fine), macaroni and cheese, Brussels sprouts cut in half, 1 slice of bread cut diagonally, fruit cocktail, apple juice and a tall beverage glass of what staff referred to as "Ensure." The need for additional staff training was evidenced by the following: 1. During the meal, at 5:37 PM, a can of Nepro	I 229	See response to federal deficiency W192.	6/30/09

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I 229	Continued From page 6 renal supplement was brought from the pantry and presented to the Residence Director (RD) and staff assisting at the dining room table. The RD shook his head, stating that was no longer the resident's supplement. He stated that Resident #2 previously had received Nepro supplement; however, it had been changed recently. The RD went in the pantry and pointed to a supply of Ross Nutrition TwoCal HN with FOS supplement. He further stated that Resident #2 received 2 cans of the TwoCal HN at each of his three meals per day (totaling 6 cans). Resident #2's medical records had been reviewed earlier that day. At approximately 3:00 PM, review of his physician's orders (POs) revealed a telephone order dated April 1, 2009 for 1 can Nepro twice daily. An April 10, 2009 order increased the supplement to 1 can three times daily. A third telephone order (with prescription) dated April 28, 2009 was to "increase Nepro food supplement to 2 cans three times daily for albumen level..." Also on April 28, 2009, a nurse documented having telephoned the primary care physician, who confirmed the latest order. The April 28, 2009 order was Resident #2's current diet order. On May 8, 2009, at approximately 2:50 PM, the Qualified Mental Retardation Professional (QMRP) was asked about Novasource Renal Supplement in the pantry. The Novasource supplement was stored next to the Nepro and TwoCal HN supplements. She stated that Resident #2 currently received the Novasource supplement, Resident #3 received Ensure and Resident #1 was tube-fed the TwoCal HN. The consulting Nutritionist was interviewed in the facility that same day, beginning at 2:55 PM. She	I 229		

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I 229	Continued From page 7 stated that Resident #2 was still prescribed Nepro supplement. She was previously unaware of the April 28, 2009 increase to 6 cans daily, as per recommendation by the nephrologist; however, she concurred with the recommendation. She further confirmed that the Ross Nutrition TwoCal HN with FOS supplement was given to Resident #1 via G-tube, for nutritional sustenance. The LPN Coordinator was interviewed just moments later, in the presence of the QMRP and Nutritionist. She stated that she had trained staff on the residents' nutritional supplements. After further discussion, she acknowledged that additional training was indicated, for staff and facility managers. Beginning at 4:00 PM, review of staff in-service training records revealed the most recent nutrition training had been documented on April 23, 2009. Observations and interviews, however, revealed that the training had not been effective. 2. During the May 6, 2009 interview with the Nutritionist, at 3:25 PM, she stated that while Resident #2's bread could be moistened (which was not the case at dinner on May 7, 2009), he should not have been given fruit cocktail. She further stated that she had trained staff to use a food processor to ensure ground texture. At 3:32 PM, the Residence Director was asked about their food processor. He replied "nobody is on a pureed diet." He retrieved the food processor from the pantry and added that he had not seen it used since he became RD, in November 2008.	I 229		
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other	I 379	See response to federal deficiency W153. The Quality Management Director will ensure that all incidents are reported to the Department of Health, Health Facilities Division per regulations. 6/30/09	

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I 379	Continued From page 8 unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview and review of incident reports and resident records, the facility failed to ensure that all incidents that presented a risk to residents' health or safety were reported immediately to the Department of Health (DOH), Health Regulation Administration, for one of the four residents in the sample. (Resident #1) The findings include: On May 6, 2009, at approximately 4:27 PM, interview with the Qualified Mental Retardation Professional (QMRP) and Residence Director (aka House Manager) revealed that Resident #1 had been in and out of the hospital several times during the previous month. However, a pre-survey review of incidents that were reported to the State agency had indicated only one recent (May 2, 2009) trip to a hospital emergency room. Subsequent review of Resident #1's nursing records and incident reports, beginning on May 7, 2009, beginning at 1:35 PM, revealed the following: 1. He was taken to a hospital emergency room (ER) on November 25, 2008 and subsequently admitted to the hospital. The discharge summary indicated his diagnoses included "fecal impaction"	I 379		

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I 379	Continued From page 9 and "aspiration of gastric contents secondary to the fecal impaction." 2. He was taken again to an ER on April 7, 2009 and subsequently admitted to the hospital. The discharge summary indicated his diagnoses included "emesis, bilateral aspiration pneumonia" and "constipation." 3. He returned to the hospital ER on April 13, 2009 and subsequently admitted. The discharge summary indicated his diagnoses included "gastritis, esophagitis" and "single non-bleeding ulcer in the body of the stomach." There was no evidence that the three aforementioned ER visits and hospitalizations had been reported to DOH/HRA.	I 379		

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R 000	INITIAL COMMENTS A licensure survey was conducted from May 6, 2009 through May 8, 2009. The Group Home for Persons with Mental Retardation (GHMRP) had a resident population of seven men with various disabilities. The findings of the survey were based on observations, interviews with residents and one guardian, interviews with staff in the home and at one day program, as well as a review of resident and administrative records, including incident reports.	R 000		
R 122	4701.2 BACKGROUND CHECK REQUIREMENT Except as provided in section 4701.6, each facility shall obtain a criminal background check, and shall either obtain or conduct a check of the District of Columbia Nurse Aide Abuse Registry, before employing or using the contract services of an unlicensed person. This Statute is not met as evidenced by: Based on interview and review of personnel records, the GHMRP failed to ensure criminal background checks had been obtained before employing or using the contract services of an unlicensed person, for 2 out of 17 direct support staff employed. (S6 and S10) The findings include: On May 7, 2009, at approximately 4:50 PM, the Qualified Mental Retardation Professional (QMRP) agreed to provide documentation needed to show evidence of criminal background checks for all staff employed in the facility. On May 8, 2009, beginning at 12:58 PM, review of personnel records revealed no documentation	R 122	The Human Resources Director will ensure that a criminal background check is completed per regulation for each employee prior to start of employment.	6/30/09

Health Regulation Administration

Marsha H. Thompson

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Director of Disability Services

(X6) DATE: 6/5/09

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R 122	Continued From page 1 available to verify that a background check had been obtained prior to employment for S6 (employment application signed July 7, 2008) and S10 (recently left the agency). It should be noted that there were 5 other direct support staff (S1, S3, S4, S5 and S7), plus the Residence Director, for which there was no evidence of comprehensive criminal background checks, to include all jurisdictions in which he/she lived or worked (see R125).	R 122		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on the review of personnel records, the GHMRP failed to ensure criminal background checks for all jurisdictions in which the employees had worked or resided within the seven (7) years prior to the check. The findings include: On May 7, 2009, at approximately 4:50 PM, the Qualified Mental Retardation Professional agreed to provide documentation needed to show evidence of criminal background checks for all staff employed in the facility. On May 8, 2009, beginning at 12:58 PM, review of personnel records revealed the following: 1. A background check for Prince Georges	R 125	See response to R122.	6/30/09

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R 125	Continued From page 2 County, MD and Lehigh County, PA had been documented for S1. However, his personnel records indicated that he had worked in Vienna (Fairfax) VA. from February 2006 up until he applied for employment on August 2, 2008. There was no evidence that a background check had been obtained in that jurisdiction. 2. A District of Columbia background check had been documented for S3. However, his personnel records indicated that he worked in Maryland in 2008. There was no evidence that a background check had been obtained in that jurisdiction. 3. District of Columbia and Prince Georges County, MD background checks had been documented for S4. However, his personnel record indicated that he had worked in Montgomery County, MD from January 2005 until July 2005. There was no evidence that a background check had been obtained in that jurisdiction. 4. A background check for Prince Georges County, MD had been documented for S5. However, his personnel records indicated that he had worked in the District of Columbia from April 1, 2008 until June 30, 2008. There was no evidence that a background check had been obtained in the District of Columbia. 5. A background check had been documented for S7 in Prince Georges County, MD and the District of Columbia. However, her personnel records indicated that she had been employed in Falls Church, VA from August 25, 2006 until she applied with this facility in August 2008. There was no evidence that a background check had been obtained in that jurisdiction.	R 125		

PRINTED: 05/26/2009
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0248	A. BUILDING _____ B. WING _____	05/08/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO	505 1/2 57TH STREET NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 125	Continued From page 3 6. A background check for Prince Georges County, MD had been documented for the Residence Director (aka House Manager). However, his personnel records indicated that he had worked in the District of Columbia from December 2006 until April 2007. There was no evidence that a background check had been obtained in the District of Columbia.	R 125		